

MEDICAL REVIEW – SOUTHERN SECTION V
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

REPORT ON THE MEDICAL AUDIT OF

HEALTH NET COMMUNITY SOLUTIONS, INC.

Contract Number: 03-76182, 07-65847, 09-86157
and 12-89334

Audit Period: May 1, 2018
Through
April 30, 2019

Report Issued: September 25, 2019

TABLE OF CONTENTS

I.	INTRODUCTION	1
II.	EXECUTIVE SUMMARY	2
III.	SCOPE/AUDIT PROCEDURES	5
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 2 – Case Management and Coordination of Care	7
	Category 3 – Access and Availability of Care	17
	Category 4 – Member’s Rights	23
	Category 5 – Quality Management	26
	Category 6 – Administrative and Organizational Capacity	31

I. INTRODUCTION

Health Net Community Solutions, Inc. (Health Net), referred to as (Plan), a wholly owned subsidiary of Centene Corporation, is a managed care organization that delivers managed health care services through health plans and government-sponsored managed care plans. Health Net's corporate headquarters are located at 21271 Burbank Boulevard, Woodland Hills, CA 91367.

Health Net offers behavioral health, substance abuse, employee assistance programs, and managed health care products including prescription drugs. Health Net also offers dental coverage for California State's Healthy Families and Medi-Cal members.

Health Net Community Solutions, Inc. operates largely as a delegated group network model. Services are delivered to members through the Plan's Participating Provider Groups (PPG), Independent Physician Association (IPA) network, or directly contracted primary care and specialty care practitioners.

Health Net Community Solutions, Inc. delivers care to members under the Two-Plan contracts covering Los Angeles, Kern, San Joaquin, Stanislaus, and Tulare counties; and Geographic Managed Care Plan contracts covering Sacramento and San Diego counties. As of April 30, 2019, the Plan's enrollment totals for its Medi-Cal line of business was 1,392,223. Membership composition by County was 954,786 for Los Angeles; 67,821 for Kern; 20,174 for San Joaquin; 63,963 for Stanislaus; 110,936 for Tulare; 106,645 for Sacramento; and 67,898 for San Diego.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the Department of Health Care Services (DHCS) medical review audit for the review period of May 1, 2018 through April 30, 2019. The on-site review was conducted from May 21, 2019 through May 31, 2019. The audit consisted of document review, verification studies, and interviews with Plan personnel.

The audit evaluated six categories of performance: Utilization Management (UM), Case Management and Coordination of Care, Access and Availability of Care, Members' Rights, Quality Management, and Administrative and Organizational Capacity.

The prior DHCS medical audit (for the period May 1, 2017 through April 30, 2018) was issued on November 6, 2018. The Corrective Action Plan (CAP) closeout letter was sent to the Plan on July 23, 2019. The audit examined documentation for compliance and to determine to what extent the Plan has operationalized their CAP.

An Exit Conference with the Plan was held on August 15, 2019. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit report findings. On August 30, 2019, the Plan submitted a response after the exit conference. The results of our evaluation of the Plan's response are reflected in this report.

The summary of the findings by category follows:

Category 1 – Utilization Management

No findings noted for the audit period.

Category 2 – Case Management and Coordination of Care

The Plan is required to use a DHCS approved Physician Certification Statement (PCS) form in determining the type of transportation service for members. The Plan did not have a process to ensure PCS forms were completed for members and included the required components.

The Plan is required to arrange for continuity of medical care for individuals who have elected hospice care, including maintaining established patient-provider relationships, to the greatest extent possible. The Plan shall cover the cost of all hospice care provided. The Plan improperly denied requests for Continuity of Care (COC) with out-of-network providers.

The Plan is required to begin to process a COC request within five working days following the receipt of the request, or three calendar days if there is a risk of harm to the member. The Plan did not begin processing COC requests within the required timeframes.

The Plan is required to provide members with pre-existing provider relationships the option to continue treatment up to 12 months with an out-of-network provider. The Plan improperly denied COC requests for members with serious chronic medical conditions who had pre-existing relationships with their physicians.

Category 3 – Access and Availability of Care

The Plan shall ensure that members receive appointments within the contract required timeframes. Our review of the Plan's process indicated when members are unable to obtain an appointment, through the Customer Contact Center (CCC), the Plan forwards the member's request for an appointment through the grievance process, which does not resolve the member's need for an appointment.

The Plan is required to pay 90 percent of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99 percent of all clean claims within 90 days. The Plan was late in paying family planning and emergency service clean claims during the audit period.

Category 4 – Member's Rights

The Plan must implement and maintain procedures to monitor the Member's Grievance System and the expedited review of grievances as required by the contract. Procedures must include, but are not limited to, systematic aggregation and analysis of the grievance data and be used for Quality Improvement (QI). Our review indicated that the Plan identified quality problems, however, it did not consistently address, correct, or follow up on problems in accordance with Plan policies.

Category 5 – Quality Management

The Plan is required to maintain a system of accountability, which includes the participation of the governing body, the designation of a QI Committee with oversight and performance responsibility, and the inclusion of contracted physicians and providers in the process of Quality Improvement System (QIS) development and performance review. The Plan's system for accountability and QI is deficient due to minimal community provider participation. Review of the Plan's UM/QI Committee Membership Roster 2018 indicated minimal involvement and attendance by contracted physicians and other providers from the community.

The Plan is required to implement an effective QIS to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf. The Plan's PQI process indicated that it did not consistently implement policies and procedures with respect to following-up with providers to address needed quality of care improvements. Our review revealed that the Plan's process, specifically relating to the severity coding level process, was not functioning as intended.

Category 6 – Administrative and Organizational Capacity

The Plan is required to report all cases of suspected fraud or abuse to DHCS where there is reason to believe that an incident of fraud or abuse has occurred by subcontractors, members, providers, or employees. The Plan's policy and procedures did not include the contract requirement of reporting all cases of suspected abuse.

The Plan is required to conduct, complete, and report to DHCS the results of a preliminary investigation of the suspected fraud or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity. The Plan did not report all suspected cases of fraud and abuse to DHCS within ten working days of Plan's notification.

II. SCOPE/AUDIT PROCEDURES

SCOPE

This audit was conducted by the DHCS Medical Review Branch to ascertain that medical services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State contracts.

PROCEDURE

The onsite review was conducted from May 21, 2019 through May 31, 2019. The audit included a review of the Plan's policies for providing services, the procedures used to implement the policies, and verification studies of the implementation and effectiveness of the policies. Documents were reviewed and interviews were conducted with the Plan administrators and staff.

The following verification studies, which include Seniors and Persons with Disabilities (SPD) members, were conducted:

Category 1 – Utilization Management

Prior authorization requests: 27 medical and 10 pharmacy prior authorization requests were reviewed for timeliness, consistent application of criteria, and appropriate review.

Appeal procedures: 13 prior authorization appeals were reviewed for appropriate and timely adjudication.

Category 2 – Case Management and Coordination of Care

Coordination of Care and Initial Health Assessment (IHA) requirements: 11 medical records were reviewed to confirm coordination of care and fulfillment of IHA requirements.

California Children's Services (CCS) requirements: Seven medical records were reviewed to evaluate coordination of CCS services.

Complex Case Management (CCM): Six files were reviewed to confirm the performance of CCM services.

Continuity of Care (COC): 10 files were reviewed to confirm the performance of COC services.

Behavioral Health Treatment (BHT): 10 files were reviewed for completeness and compliance with BHT requirements.

Non-Emergency Medical Transportation (NEMT): 18 claims were reviewed to confirm compliance with NEMT requirements.

Non-Medical Transportation (NMT): 20 claims were reviewed to confirm compliance with the NMT requirements.

Category 3 – Access and Availability of Care

Appointment availability verification: a total of 17 providers from the Plan's directory, including routine, urgent, specialty, and prenatal care were reviewed. The third next available appointments were used to measure access to care.

Claims: 10 emergency services and 10 family planning claims were reviewed for appropriate and timely adjudication.

Category 4 – Member's Rights

Grievance Procedures: 30 grievances (12 quality of care, 10 quality of service, five exempt, three expedited) and six inquiries were reviewed for timely resolution, response to complainant, and submission to appropriate level for review.

Health Insurance Portability and Accountability Act (HIPAA): 11 HIPAA cases were reviewed for appropriate reporting and proper treatment.

Category 5 – Quality Management

Provider Training: 16 new provider training records were reviewed for timely provision of Medi-Cal Managed Care program training.

Potential quality of care issues: Five cases were reviewed for appropriate reporting and proper treatment.

Category 6 – Administrative and Organizational Capacity

Fraud and Abuse: 10 fraud and abuse cases were reviewed for appropriate reporting and processing.

A description of the findings for each category is contained in the following report.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

CATEGORY 2 – CASE MANAGEMENT AND COORDINATION OF CARE

2.4

NON-EMERGENCY MEDICAL TRANSPORTATION/ NON-MEDICALTRANSPORTATION

Non-Emergency Medical Transportation means ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2 rendered by licensed providers.

GMC/2-Plan Contracts E.E.1 Definitions

Non-Emergency Medical Transportation Requirements:

NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when it is prescribed in writing by a physician, dentist, or podiatrist. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 12501.

MMCD All Plan Letter 17-010

NEMT Physician Certification Statement Forms:

MCPs (Medi-Cal managed care health plans) and transportation brokers must use Physician Certification Statement (PCS) forms to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization.

MMCD All Plan Letter 17-010

Non-Medical Transportation means transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.

GMC/2-Plan Contracts E.E.1 Definitions

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

Non-Medical Transportation Requirements:

NMT has been a covered benefit when provided as an EPSDT service. Effective July 1, 2017, NMT is a Medi-Cal managed care benefit for all members to obtain medically necessary covered services. Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system. NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver.

MMCD All Plan Letter 17-010

Non-Medical Transportation Authorization:

MCPs may authorize NMT for each member prior to the member using NMT services. The MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter.

MMCD All Plan Letter 17-010

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards:

MCPs are contractually required to meet timely access standards (28 CCR Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)). MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

MMCD All Plan Letter 17-010

Conditions for Non-Medical Transportation Services:

- MCP may use prior authorization processes for approving NMT services and shall re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments not related to medically necessary covered Medi-Cal benefits.
- The member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
 - Has no valid driver's license.
 - Has no working vehicle available in the household.
 - Is unable to travel or wait for medical or dental services alone.
 - Has a physical, cognitive, mental, or developmental limitation.

MMCD All Plan Letter 17-010

Written Member Information:

The Member Services Guide ... shall include the following information: ...12)

Procedures for obtaining any transportation services to Service Sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.

GMC/2-Plan Contracts E.A.13.4.D

SUMMARY OF FINDING:

2.4.1 Non-Emergency Medical Transportation (NEMT) Physician Certification Statement (PCS)

All Plan Letter (APL) 17-010 requires MCPs and transportation brokers to use a DHCS approved Physician Certification Statement (PCS) form in determining the type of transportation service for members. The MCP cannot modify the form of transportation prescribed by the physician. All NEMT PCS forms must include the following components:

- Function limitations justification
- Dates of service needed which may be a maximum of 12 months
- Mode of transportation needed, either ambulance, gurney/litter van, wheelchair van or air transport

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net Community Solutions, Inc.
AUDIT PERIOD: May 1, 2018 through April 30, 2019 DATE OF AUDIT: May 21, 2019 through May 31, 2019

- Prescribing physician's statement certifying medical necessity for the type of transportation

Policy and Procedure CA.LTSS.15: Non-Medical Transportation (NMT) and NEMT Transportation for Medi-Cal Members establishes the guidelines relative to the arrangement and oversight of transportation services provided to Medi-Cal members. The Plan subcontracts NEMT and NMT services. Subcontractor initiates the PCS form that is sent to the treating physician who completes the form as required.

The Plan did not ensure subcontractors completed the DHCS approved PCS form. Physician Certification Forms from subcontractor were either missing or incomplete. Verification study revealed the following:

- Ten PCS forms were missing.
- Three PCS forms were lacking duration of service or dates of service needed.

The Plan did not have a process to ensure completion of the PCS form. Without a PCS form or a fully completed PCS form from the treating physician, medically necessary transportation services to members may be compromised.

RECOMMENDATION:

2.4.1 Revise and implement policies and procedures to ensure DHCS approved PCS form is completed prior to providing transportation services.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

2.5

CONTINUITY OF CARE

Medi-Cal members assigned a mandatory aid code and who are transitioning from Medi-Cal fee-for-service (FFS) into a Medi-Cal managed care health plan (MCP) have the right to request continuity of care in accordance with state law and the MCP contracts. All MCP members with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services that have been receiving through Medi-Cal FFS or through another MCP.

Members, their authorized representatives on file with Medi-Cal, or their provider, may make a direct request to an MCP for continuity of care. When this occurs, the MCP must begin to process the request within five working days following the receipt of the request. However, the request must be completed in three calendar days if there is risk of harm to the member. The continuity of care process begins when the MCP starts the process to determine if the member has a pre-existing relationship with the provider.

MCPs must accept requests for continuity of care over the telephone, according to the requester's preference, and must not require the requester to complete and submit a paper or computer form if the requester prefers to make the request by telephone. To complete a telephone request, the MCP may take any necessary information from the requestor over the telephone.

MCPs shall accept and approve retroactive requests for continuity of care that meet all continuity of care requirements noted above and in 1-3 below. The services that are the subject of the request must have occurred after the member's enrollment into the MCP, and the MCP must have the ability to demonstrate that there was an existing relationship between the member and provider prior to the member's enrollment into the MCP. MCPs shall only approve retroactive requests that meet the following requirements:

1. Have dates of services that occur after the effective date of this APL;
2. Have dates of services within 30 calendar days of the first day of service for which the provider is requesting, or has previously requested, continuity of care retroactive reimbursement; and
3. Are submitted within 30 calendar days of the first service for which retroactive continuity of care is being requested.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

2.5

CONTINUITY OF CARE

The MCP should determine if a relationship exists through use of data provided by DHCS to the MCP, such as Medi-Cal FFS utilization data.

Each continuity of care request must be completed within the following timeline:

- Thirty calendar days from the date the MCP received the request;
- Fifteen calendar days if the member's medical condition requires more immediate attention, such as upcoming appointments or other pressing care needs; or,
- Three calendar days if there is risk of harm to the member.

A continuity of care request is considered completed when:

- The member is informed of his or her right of continued access;
- The MCP and the out-of-network FFS or prior MCP provider are unable to agree to a rate;
- The MCP has documented quality of care issues; or
- The MCP makes a good faith effort to contact the provider and the provider is non-responsive for 30 calendar days.

Upon approval of a continuity of care request, the MCP must notify the member of the following within seven calendar days:

- The request approval;
- The duration of the continuity of care arrangement;
- The process that will occur to transition the member's care at the end of the continuity of care period; and
- The member's right to choose a different provider from the MCP's provider network.

The MCP must notify the member 30 calendar days before the end of the continuity of care period about the process that will occur to transition his or her care at the end of the continuity of care period. This process includes engaging with the member and provider before the end of the continuity of care period to ensure continuity of services through the transition to a new provider.

APL 18-008

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

SUMMARY OF FINDINGS:

2.5.1 Continuity of Care for Out-of-Network Providers

The Contract states, “For individuals who have elected hospice care, Contractor shall arrange for continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible. Contractor shall cover the cost of all hospice care provided. Contractor is also responsible for all medical care not related to the terminal condition.”

(GMC/2-Plan Contract A.10.C.1)

All Plan Letter (APL) 18-008: Continuity of Care Medi-Cal Members who transition into Medi-Cal Managed Care “have the right to request continuity of care in accordance with state law, and the MCP contract. All MCP members with pre-existing provider relationships who make a continuity of care request to an MCP must be given the option to continue treatment for up to 12 months with an out-of-network Medi-Cal provider. These eligible members may require continuity of care for services they have been receiving through Medi-Cal FFS or through another MCP.” This APL supersedes APL 15-019.

Plan’s Policy and Procedure CA.LTSS.05: Continuity of Care (COC) for Medi-Cal states “All Health Net members with pre-existing provider relationships who make a continuity of care request to Health Net must be given the option to continue treatment for up to twelve (12) months with an out-of-network Medi-Cal provider. These eligible beneficiaries may require continuity of care for services they had been receiving through FFS Medi-Cal or through another managed care program”. The Plan’s policy and procedure pertaining to “COC Criteria” is consistent with APLs 15-019 and 18-008.

Plan’s Policy and Procedure MS1228-15444: Continuity of Care with Terminated or Non-Contracted Providers further states “For members who have elected hospice care, Health Net shall arrange for continuity of medical care, including maintaining established patient-provider relationships, to the greatest extent possible. Health Net shall cover the cost of all hospice care provided.”

The Plan improperly denied requests for COC with out-of-network providers. During the interview, the Plan stated if the Provider Physician Group (PPG) denies services for any reason it will be processed as an automatic denial and referred to Appeals and Grievances.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

The verification study identified one case where the COC request was denied for hospice services without following the Plan's policies and procedures for "COC Criteria". Member's request was denied by the PPG due to being out-of-network and the case was closed as declined and referred to appeals program.

According to the Plan, COC services are automatically denied and referred to appeals if PPG denies services for out-of-network. The Plan is not implementing their policy for COC.

Without proper implementation of policies and procedures for COC services with out-of-network providers, it may interrupt services and affect member's care.

2.5.2 Initiation of Continuity of Care (COC) Process

All Plan Letter (APL) 18-008 states, the MCP must begin to process the COC request "within five working days following the receipt of the request. However, the request must be completed in three calendar days if there is a risk of harm to the member."

Plan's Policy and Procedure CA.LTSS.05: Continuity of Care (COC) for Medi-Cal states that if the member is active or has a future effective date with the Plan, a Public Program Specialist attempts to contact the member, telephonically, no later than five (5) business days from the date of the COC request. However if there is risk of harm to the member, the request is completed in three (3) calendar days.

The Plan did not process COC requests within the required timeframes. The verification study identified two cases where the Plan did not begin to process the COC request within 5 working days. The Plan is not implementing their policy to begin the COC process within APL requirements.

If the Plan does not begin to process member's request for COC in a timely manner, medically necessary services can be interrupted and access to care may be delayed.

2.5.3 Continuity of Care for Serious Chronic Conditions

The Plan shall implement and maintain a written description of its Quality Improvement System that shall include a description of activities used by members that are Seniors and Persons with Disabilities and chronic conditions, designed to assure the provision of case management, coordination and continuity of care services.
(GMC/2-Plan Contract A.4.7.I)

All Plan Letter (APL) 18-008: Continuity of Care Medi-Cal Members who Transition into Medi-Cal Managed Care states that all MCP members with pre-existing provider

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

relationships who make a COC request to an MCP must be given the option to continue treatment up to 12 months with an out-of-network Medi-Cal Provider. Following identification of a pre-existing relationship, MCP's must provide COC with an out-of-network provider when the provider supplies all relevant treatment information, for the purposes of determining medical necessity, as well as a current treatment plan, as long it is allowable under federal and state privacy laws and regulations. This APL supersedes APL 15-019.

Health and Safety Code, Section 1373.96 states that health care service plans shall provide the completion of covered services for a serious chronic condition. A serious chronic condition is defined as a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Plan Policy and Procedure MS1228-15444: Continuity of Care with Terminated or Non-Contracted Providers states, that COC cases are considered for completion of services based on the Plan's benefits, medical appropriateness, member needs, and qualifying medical condition where applicable. Further, Plan's policy definition of a serious chronic condition is consistent with regulations.

Plan Policy and Procedure CA LTSS.05: Continuity of Care for Medi-Cal Members who Transition into Medi-Cal Managed Care states, "All Health Net members with pre-existing provider relationships who make a COC request to Health Net must be given the option to continue treatment for up to twelve (12) months with an out-of-network Medi-Cal provider. Upon request of the enrollees, their authorized representative or provider, the Plan will allow enrollees to maintain their current providers, including non-participating providers who are not in the same PPG as the member's Primary Care Physician (PCP)."

The Plan improperly denied COC for serious chronic conditions. The verification study indicated that request for COC was denied for serious chronic medical conditions despite a pre-existing relationship with a physician. The Plan determined that there was no "active course of treatment".

The Plan's definition of a "serious chronic condition" was not used appropriately in the determination of medical necessity for COC. "Active course of treatment" was used by the Plan as an additional factor in considering what constitutes a "serious chronic condition". The Plan is not implementing their policy appropriately for COC.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net Community Solutions, Inc.
AUDIT PERIOD: May 1, 2018 through April 30, 2019 DATE OF AUDIT: May 21, 2019 through May 31, 2019

Requiring additional factors for medical necessity determination in assessing COC requests for a member with pre-existing relationship with the physician can potentially lead to a denial and delay in the care and treatment of a member's serious chronic condition.

RECOMMENDATIONS:

2.5.1 Develop and maintain a process to deliver COC services according to contract and APL requirements.

2.5.2 Develop a system to ensure that COC requests are processed in compliance with APL requirements.

2.5.3 Improve the Plan's process in determining the medical necessity for a "serious medical condition" and ensure that COC is approved for members that meet the criteria.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

CATEGORY 3 – ACCESS AND AVAILABILITY OF CARE

3.1

APPOINTMENT PROCEDURES AND MONITORING WAITING TIMES

Appointment Procedures:

Contractor shall implement and maintain procedures for Members to obtain appointments for routine care, urgent care, routine specialty referral appointments, prenatal care, children's preventive periodic health assessments, and adult initial health assessments. Contractor shall also include procedures for follow-up on missed appointments.

GMC/2-Plan Contract A.9.3.A

Members must be offered appointments within the following timeframes:

- 3) Non-urgent primary care appointments – within ten (10) business days of request;
- 4) Appointment with a specialist – within 15 business days of request;

GMC/2-Plan Contract A.9.4.B

Prenatal Care:

Contractor shall ensure that the first prenatal visit for a pregnant Member will be available within two (2) weeks upon request.

GMC/2-Plan Contract A.9.3.B

Monitoring of Waiting Times:

Contractor shall develop, implement, and maintain a procedure to monitor waiting times in the providers' offices, telephone calls (to answer and return), and time to obtain various types of appointments...

GMC/2-Plan Contract A.9.3.C

Member Services:

Compliance with the following may be met through distribution of a provider directory:

The name, provider number, address and telephone number of each Service Location (e.g., locations of hospitals, Primary Care Physicians (PCP), specialists, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, FQHCs, Indian Health Programs). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, provider number, address and telephone number shall appear for each physician provider:

2-Plan Contract A.13.D.4

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

Member Services:

Compliance with the following may be met through distribution of a Provider Directory:

The address and telephone number of each Service Location (e.g., locations of hospitals, Primary Care Physicians (PCP), optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, Federally Qualified Health Centers (FQHC), Indian Health Centers). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, address and telephone number shall appear for each Physician provider:

GMC Contract A.13.D.4

Provider Directory:

Health and Safety Code Section 1367.27(a) states, "Commencing July 1, 2016, a health care service plan shall publish and maintain a provider directory or directories with information on contracting providers that deliver health care services to the Plan's enrollees, including those that accept new patients."

Health and Safety Code Section 1367.27(a)

SUMMARY OF FINDING:

3.1.1 Accessibility to Providers

The Plan shall ensure that members must be offered appointments within the following timeframes: first prenatal visit within 2 weeks, non-urgent primary care within 10 business days, and specialist within 15 business days.

(GMC / 2-Plan Contract A.9.3.B & A.9.4.B)

The Plan's Policy and Procedure CA.NM.05: Appointment Accessibility for Commercial & SHP (Medi-Cal) states "non-urgent appointments for primary care, regular and routine care (PCP): appointment within 10 business days of request...non-urgent appointments with specialist (SCP): appointment within 15 business days of request...first prenatal visit, PCP & SCP: appointment within 10 business days of request."

The Plan's Policy and Procedure, Customer Contact Center (CCC) Accessibility of Providers delineates the Plan's process when a member cannot get an appointment. Policy states "If the issue has not been resolved by the close of the next business day, the CCC Representative will immediately file a Formal Grievance (or an Expedited Appeal) by sending the Service Form/Action Gram to the Appeals and Grievance Department (A&G). The Representative will advise the member that an

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net Community Solutions, Inc.
AUDIT PERIOD: May 1, 2018 through April 30, 2019 DATE OF AUDIT: May 21, 2019 through May 31, 2019

acknowledgment letter will be sent within five calendar days. An A&G Representative will contact and resolve the member grievance within 30 calendar days.”

The Plan does not ensure that members receive appointments within the required timeframes. In cases when members cannot obtain an appointment, the Plan’s process is to file a formal grievance, which does not resolve the member’s need for an appointment.

The Plan’s policy and procedures conflicted with appointment timeframe requirements. The process incorrectly forwards unresolved appointment requests to A&G.

Access to care may be delayed if a request for an appointment is forwarded through the grievance process.

RECOMMENDATION:

3.1.1 Revise and implement policies and procedures to ensure appointment availability timeframes are met.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

3.3

EMERGENCY SERVICES AND FAMILY PLANNING CLAIMS

For all other non-contracting providers, reimbursement by Contractor, or by a subcontractor who is at risk for out-of-plan emergency services, for properly documented claims for services rendered on or after January 1, 2007 by a non-contracting provider pursuant to this provision shall be made in accordance with Provision 5, Claims Processing, and 42 USC Section 1396u-2(b)(2)(D).

Contractor shall cover emergency medical services without prior authorization pursuant to 28 CCR 1300.67(g)(1).

GMC Contract A.9.7.A

Contractor shall cover emergency medical services without prior authorization pursuant to Title 28 CCR, Section 1300.67(g) and Title 22 CCR Section 53216.

2-Plan Contract A.9.7.A

Family Planning (Claims):

Contractor shall reimburse non-contracting family planning providers at no less than the appropriate Medi-Cal FFS rate....(as required by Contract)

GMC/2-Plan Contract A.8.9

Claims Processing—Contractor shall pay all claims submitted by contracting Providers in accordance with this section...Contractor shall comply with 42 USC 1396a(a)(37) and Health and Safety Code Sections 1371 through 1371.39.

GMC Contract A.8.5

Claims Processing—Contractor shall pay all claims submitted by contracting providers in accordance with this section...Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36.

2-Plan Contract A.8.5

Contractor shall pay all claims submitted by contracting providers in accordance with this section, unless the contracting provider and Contractor have agreed in writing to an alternate payment schedule...Contractor shall pay 90% of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days. The date of receipt shall be the date Contractor receives the claim, as indicated by its date stamp on the claim. The date of payment shall be the date of the check or other form of payment.

2-Plan Contract A.8.5.B

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

The Social Security Act 1902(a)37(A) “ provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims.

Time for Reimbursement. A plan and a plan's capitated provider shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than thirty (30) working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, or if the plan is a health maintenance organization, 45 working days after the date of receipt of the complete claim by the plan or the plan's capitated provider, unless the complete claim or portion thereof is contested or denied, as provided in subdivision (h).

CCR, Title 28, Section 1300.71(g)

SUMMARY OF FINDING:

3.3.1 Emergency and Family Planning Claims Processing

The Plan shall pay 90% of all clean claims from practitioners who are in individual or group practices or who practice in shared health facilities, within 30 days of the date of receipt and 99% of all clean claims within 90 days.

(2-Plan Contract A.8.5.B)

The Social Security Act 1902(a)37(A) states “ provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 90 days of the date of receipt of such claims.”

The Plan's Policy and Procedure 06-0106K: DMHC Regulatory Requirements states that all uncontested claims must be paid, contested or denied within 45 working days of receipt. DHCS requirement is 90% within 30 calendar days and 99% within 90 calendar days.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net Community Solutions, Inc.
AUDIT PERIOD: May 1, 2018 through April 30, 2019 DATE OF AUDIT: May 21, 2019 through May 31, 2019

The Plan did not meet contract requirements to pay 90 percent of all clean claims within 30 days of the date of receipt and 99 percent of all clean claims within 90 days.

The Plan's Turnaround Time Summary was reviewed and demonstrated noncompliance for 8 months with the contract requirements to pay 90 percent of all clean claims within 30 calendar days. The average turnaround time in those 8 months was 79.7 percent. Further, the Plan did not meet the 99 percent requirement to pay all clean claims within the 90 calendar days for 8 months. The average turnaround time in those 8 months was 93.7 percent.

During the interview, the Plan explained the Medi-Cal claims team experienced unexpected and significant staffing attrition at the end of the third quarter and throughout the fourth quarter of 2018. In addition, the Plan's ability to fill and train new staff took longer than anticipated. This reduced the Plan's ability to process claims in a timely manner during the audit period.

If family planning and emergency services are not paid timely by the Plan, member services may be interrupted or delayed since providers may not want to see members if they cannot get paid or while waiting for payment.

RECOMMENDATION:

3.3.1 Monitor and ensure the Plan's ability to process and pay clean family planning and emergency service claims in accordance with contract requirements.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

CATEGORY 4 – MEMBER’S RIGHTS

4.1

GRIEVANCE SYSTEM

Member Grievance System and Oversight:

Contractor shall implement and maintain a Member Grievance system in accordance with 28 CCR 1300.68 (except Subdivision 1300.68(g).), and 1300.68.01, 22 CCR 53858, Exhibit A, Attachment 13, Provision 4, Subprovision D, item 12), and 42 CFR 438.420(a)-(c).

GMC Contract A.14.1

Contractor shall implement and maintain a Member Grievance System in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22 CCR Section 53858, Exhibit A, Attachment 13, Provision 4, Paragraph D.13), and 42 CFR 438.420(a)-(c).
2-Plan Contract A.14.1

Contractor shall implement and maintain procedures to monitor the Member’s Grievance system and the expedited review of grievances required under 28 CCR 1300.68 and 1300.68.01 and 22 CCR 53858....(as required by Contract). Procedures shall include, but not limited to, systematic aggregation and analysis of the grievance data and use for Quality Improvement.

GMC Contract A.14.2

Contractor shall implement and maintain procedures to monitor the Member’s grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22 CCR Section 53858....(as required by Contract). Procedures shall include, but not limited to, systematic aggregation and analysis of the grievance data and use for Quality Improvement.
2-Plan Contract A.14.2

Contractor shall maintain, and have available for DHCS review, grievance logs, including copies of grievance logs of any subcontracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22 CCR Section 53858(e).

GMC/2-Plan Contract A.14.3.A

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

SUMMARY OF FINDING:

4.1.1 Potential Quality Issues (PQI) Related to Grievances

The Plan shall implement and maintain procedures to monitor the Member's Grievance System and the expedited review of grievances required under CCR, Title 28, sections 1300.68 and 1300.68.01 and CCR, Title 22, section 53858. Procedures shall include, but are not limited to, systematic aggregation and analysis of the grievance data, and use for QI.

(GMC / 2 Plan Contract A.14.2)

The Plan's Appeals and Grievances Policy and Procedure GA-201ML: (FB222-141813) Medi-Cal Member Grievance Process states that each grievance case is evaluated to determine if there is an identifiable trend with respect to clinical or service issues so that follow-up action can be taken. Based on the severity outcome level code, actions taken may include but are not limited to: track and trend, request Corrective Action Plan from provider, send educational letter to provider, and refer case to the Peer Review Committee.

The Plan's Policy and Procedure: Follow-Up on Quality of Care Concerns states that Health Net, as part of the Plan's Quality Management Program, monitors and evaluates the care provided to members and action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated. The process is designed to address all contracting practitioners, providers and entities.

The Plan's Quality Improvement Program Description 2019 explains the process in the handling of clinical Quality of Care/PQI and communication to network providers is a major component of supporting Health Net's QI initiatives and studies.

The Plan's grievance system process did not consistently collect, aggregate, and analyze grievance data for QI by the organization. The review indicated that the Plan identified quality problems, however, it did not consistently address, correct, or follow up on problems in accordance with the Plan's policies.

The verification study revealed the following:

- In one sample of an expedited grievance case, Grievance Resolution Letter to the member indicated that the issue(s) were "forwarded" to delegated entity QM Department and/or Quality Medical Director for review. However, there was no indication of further Plan QM process involvement and/or follow-up communication with delegated entity and/or providers by the Plan specifically.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

- In another example, the Grievance Resolution Letter stated, “As part of our investigation we contacted PPG and asked that they address the issues you raised. Please be assured that Health Net has taken all necessary actions as a result of this investigation, and will continue to monitor the service of this provider.” Although Plan’s action is appropriate, there is no reference to subjecting the issues to the Plan’s formal QI process in following up with the PPG and provider from a broader system perspective for greater organizational improvement.
- For three exempt grievance cases reviewed regarding provider service, provider care, and pharmacy/prescriptions, there was no indication that issues were referred for further Plan QI process to the related delegated entity and providers.

The Plan’s system did not ensure a control mechanism for addressing grievance related PQI information for follow-up and integration within the network for process improvement.

Deficiency in the collection, compilation, and analysis of grievance data for QI can potentially lead to lost opportunities to improve service and care to members.

RECOMMENDATION:

- 4.1.1** Develop and implement oversight, monitoring, and controls utilized in ensuring that PQI identified in the investigation and resolution of grievances are collected and analyzed for systemic QI, including feedback and follow-up with delegated entities and contracted providers.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

CATEGORY 5 - QUALITY MANAGEMENT

5.1

QUALITY IMPROVEMENT SYSTEM/ DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

General Requirements:

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider.

GMC/2-Plan Contract A.4.1

Written Description: Contractor shall implement and maintain a written description of its QIS [Quality Improvement System]...(as required by Contract)

GMC/2-Plan Contract A.4.7.A-I

Accountability: Contractor shall maintain a system of accountability which includes the participation of the governing body of the Contractor's organization, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the medical director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review....

GMC/2-Plan Contract A.4.2

Governing Body: Contractor shall implement and maintain policies that specify the responsibilities of the governing...(as required by Contract)

GMC/2-Plan Contract A.4.3.A-D

Provider Participation: Contractor shall ensure that contracting physicians and other providers from the community shall be involved as an integral part of the QIS. Contractor shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.

GMC2-Plan Contract A.4.5

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

5.1

QUALITY IMPROVEMENT SYSTEM/ DELEGATION OF QUALITY IMPROVEMENT ACTIVITIES

Delegation of Quality Improvement Activities:

- A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum:
 - 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
 - 2) Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
 - 3) Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
 - 4) Contractor's actions/remedies if subcontractor's obligations are not met.

- B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:
 - 1) Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
 - 2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.
 - 3) Includes the continuous monitoring, evaluation and approval of the delegated functions.

GMC/2-Plan Contract A.4.6

SUMMARY OF FINDINGS:

5.1.1 Community Provider Participation

The Plan shall maintain a system of accountability which includes the participation of its governing body, the designation of a quality improvement committee with oversight and performance responsibility, the supervision of activities by the Medical Director, and the inclusion of contracted physicians and contracted providers in the process of QIS development and performance review.

(GMC/2-Plan Contract A.4.2)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

The Plan shall ensure that contracting physicians and other providers from the community shall be involved as an integral part of the QIS. Plan shall maintain and implement appropriate procedures to keep contracting providers informed of the written QIS, its activities, and outcomes.

(GMC/2-Plan Contract A.4.5)

The Plan's Quality Improvement Program Description 2019 states that the UM/QI Committee is chaired by a Chief Medical Director, identified by the Chief Medical Officer, and meets quarterly. External practitioners participate on this committee along with the Plan's representatives from Mental Health Network Services, Pharmacy Department, Dental Department, Network Management, Regional Medical Directors, Customer Service Operations, Medical Management, Credentialing, Peer Review, and Utilization Management.

UM/QI Committee meets on a quarterly basis. Review of the Plan's UM/QI Committee Membership Roster 2019 indicated minimal involvement and attendance by contracted physicians and other providers from the community. "External Physician Voting Members" listed four providers; however two were mental/behavioral providers located in Texas. Minutes and attendance lists indicate Quorum would be (9) voting members. Review of attendance indicates minimal involvement and attendance by community providers which is not sufficient to achieve Plan's objectives for accountability and QI.

During the interview, the Plan explained the difficulty in recruiting community providers for the regular commitment necessary to meet these requirements. The Plan did not meet contract requirements.

Lack of appropriate California licensed contracted community physicians/providers participation in the UM/QI Committee meetings preclude their optimal involvement in the process of QIS development and performance review. This could limit the effectiveness in the operation of the QIS for process and organizational improvement for the benefit of members.

5.1.2 Potential Quality Improvement (PQI) Issues

The Plan shall implement an effective QIS to monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. The Plan shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between the Plan and the provider.

(GMC/2-Plan A.4.1)

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

The Plan shall implement and maintain procedures to monitor the Member's Grievance System and the expedited review of grievances, including procedures for systematic aggregation and analysis of the grievance data and use for Quality Improvement. (GMC/2-Plan A.14.2.B)

The Plan's Appeals & Grievances Policy and Procedure GA-201ML: Medi-Cal Member Grievance Process (FB222-141813) states that each grievance case is evaluated to determine if there is an identifiable trend with respect to clinical or service issues. Severity outcome codes are classified as level 0-4. Based on the severity outcome level code, actions taken may include but are not limited to: track and trend, request Corrective Action Plan from provider, send educational letter to provider, refer case to the Peer Review Committee.

The Plan's Policy and Procedure: Follow-Up on Quality of Care Concerns states that the Plan's Quality Management Program monitors and evaluates the care provided to members and action is taken to improve care where deficiencies are identified, and follow-up is planned where indicated. The process is designed to address all contracting practitioners, providers, and entities.

Although the Plan has grievances and quality of care policies in place, review of the Plan's PQI process indicated that they were not consistently implemented, specifically relating to the Plan's severity coding level process.

The verification study revealed in two PQI instances wherein the Plan did not properly complete the QI process with respect to following-up with providers.

- In one sample, medical records were incomplete to determine the appropriate severity code level. Further, there was no indication of the Plan's effort to communicate with providers to further analyze this episode for QI purposes.
- In another sample, procedures that provider used for informed consent were flawed. Furthermore, the provider inappropriately charged the member for cancelling services. There was no indication of the Plan's efforts to follow-up with provider and/or delegated entity for QI.

During the interview, the Plan acknowledged that their procedures did suggest potential flaws whereby PQI coded at lower levels of severity could be overlooked in the process. The Plan did not conduct a complete QI review and did not follow up with providers.

Deficits in the operational system for investigating PQI creates possible missed opportunities for QI and can adversely impact the service and care for members.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net Community Solutions, Inc.
AUDIT PERIOD: May 1, 2018 through April 30, 2019 DATE OF AUDIT: May 21, 2019 through May 31, 2019

RECOMMENDATIONS:

- 5.1.1 Revise QI procedures to ensure that contracting physicians and other providers from the community are involved as an integral part of the QIS.
- 5.1.2 Develop oversight and revise process to ensure that PQI are analyzed for QI and enhance controls to ascertain that issues coded at lower level severity are followed-up with delegated entities and contracted providers.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

CATEGORY 6 – ADMINISTRATIVE AND ORGANIZATIONAL CAPACITY

6.2

FRAUD AND ABUSE

Fraud and Abuse Reporting:

Contractor shall meet the requirements set forth in 42 CFR 438.608 by establishing administrative and management arrangements or procedures, as well as a mandatory compliance plan, which are designed to guard against fraud and abuse....

- 1) Contractor shall establish an Anti-Fraud and Abuse Program in which there will be a compliance officer and a compliance committee for all fraud and/or abuse issues, and who shall be accountable to senior management. This program will establish policies and procedures for identifying, investigating and providing a prompt response against fraud and/or abuse in the provision of health care services under the Medi-Cal Program, and provide for the development of corrective action initiatives relating to the contract.
- 2) Contractor shall provide effective training and education for the compliance officer and all employees.
- 3) Contractor shall make provision for internal monitoring and auditing including establishing effective lines of communication between the compliance officer and employees and enforcement of standards through well-publicized disciplinary guidelines.
- 4) Fraud and Abuse Reporting—Contractor shall report to DHCS all cases of suspected fraud and/or abuse where there is reason to believe that an incident of fraud and/or abuse has occurred by subcontractors, members, providers, or employees. Contractor shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud and/or abuse within 10 working days of the date Contractor first becomes aware of, or is on notice of, such activity....
- 5) Tracking Suspended Providers—Contractor shall comply with 42 CFR 438.610. Additionally, Contractor is prohibited from employing, contracting or maintaining a contract with physicians or other health care providers that are excluded, suspended or terminated from participation in the Medicare or Medi-Cal/Medicaid programs....

GMC Contract E.2.24.B/2-Plan Contract E.2.26.B

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

SUMMARY OF FINDINGS:

6.2.1 Fraud and Abuse Policies and Procedures

The Plan shall report to DHCS all cases of suspected fraud or abuse where there is reason to believe that an incident of fraud or abuse has occurred by subcontractors, members, providers, or employees. The Plan shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity.

(GMC Contract E.2.24.B.1. / 2-Plan Contract E. 2.26.B.4)

The Plan's Policy CC.COMP.16 Fraud, Waste and Abuse Plan, Attachment E, Section V (State/Federal Reporting), B.1. states, "Within ten (10) business days of the health plan being notified by the Special Investigations Unit (SIU) (or other sources) of suspected fraud, the Compliance Officer will report the issue to DHCS Medi-Cal Managed Care Department Program Integrity, the [Bureau of Medi-Cal Fraud & Elder Abuse of the Department of Justice] CA DOJ BMFEA and/or or local law enforcement.

The Plan's policy and procedures did not include the contract requirement of reporting to DHCS all cases of suspected abuse.

The Plan was unaware that their policy and procedures were not consistent with contract requirements to report all cases of suspected abuse.

If the Plan's policy and procedures does not include the reporting of suspected abuse, the Plan may not report cases of abuse and may allow further incidents to occur.

6.2.2 Fraud and Abuse Reporting

The Plan shall report to DHCS all cases of suspected fraud or abuse where there is reason to believe that an incident of fraud or abuse has occurred by subcontractors, members, providers, or employees. The Plan shall conduct, complete, and report to DHCS, the results of a preliminary investigation of the suspected fraud or abuse within 10 working days of the date the Plan first becomes aware of, or is on notice of, such activity.

(GMC Contract E.2.24.B.1. / 2-Plan Contract E. 2.26.B.4)

Plan's Policy CC.COMP.16 Fraud, Waste and Abuse Plan, Attachment E, Section V (State/Federal Reporting), B.1, states, "Within ten (10) business days of the health plan being notified by the Special Investigations Unit (SIU) (or other sources) of suspected fraud, the Compliance Officer will report the issue to DHCS Medi-Cal Managed Care

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖

PLAN: Health Net Community Solutions, Inc.

AUDIT PERIOD: May 1, 2018 through April 30, 2019

DATE OF AUDIT: May 21, 2019 through May 31, 2019

Department Program Integrity, the [Bureau of Medi-Cal Fraud & Elder Abuse of the Department of Justice] CA DOJ BMFEA and local law enforcement.

The Plan did not report all suspected cases of fraud or abuse to DHCS within ten working days of the Plan's notification. The Plan only reports cases of credible allegation of fraud, rather than suspected cases of fraud or abuse.

The verification study revealed the following deficiencies:

- In two of ten cases reviewed, the Plan submitted fraud or abuse reports 19 and 22 working days after the Preliminary Investigative reports were completed.
- In four of ten cases reviewed, the Plan did not submit fraud and abuse reports although the Plan's preliminary investigations indicate suspicion of fraud and abuse.

The Plan explained during the interview its criteria for determining whether a fraud or abuse report should be prepared and submitted. The Plan responded that patterns are sometimes false leads and the Plan wanted to ensure the case is actual fraud. A fraud or abuse report is not submitted for potential fraud. The Plan also stated there was uncertainty of how to determine when to start counting the ten days for submitting a fraud or abuse report. Furthermore, in the DHCS Fraud and Abuse Program Questionnaire completed by the Plan, it stated that the Plan notifies DHCS "within ten days of discovering a credible allegation of fraud or abuse."

The Plan's failure to report suspected fraud or abuse in a timely manner may result in potential underreporting and compromise the integrity of the Plan and the Medi-Cal Program.

RECOMMENDATIONS:

- 6.2.1** Revise policy and procedures to include the reporting of suspected cases of "abuse" to DHCS within ten working days of the date the Plan first becomes aware of such activity.
- 6.2.2** Implement procedures to report preliminary investigations of all suspected cases of fraud or abuse to DHCS within ten working days which the Plan first becomes aware of such activity.

MEDICAL REVIEW – SOUTHERN SECTION V
AUDITS AND INVESTIGATIONS
DEPARTMENT OF HEALTH CARE SERVICES

Health Net Community Solutions, Inc.

Contract Number: 03-76208, 07-65848, 09-86158, and
12-89335
State Supported Services

Audit Period: May 1, 2018
Through
April 30, 2019

Report Issued: September 25, 2019

TABLE OF CONTENTS

I. INTRODUCTION1

II. COMPLIANCE AUDIT FINDINGS2

INTRODUCTION

This audit report presents findings of the Health Net Community Solutions, Inc. (the Plan) compliance and its implementation of the State Supported Services contract with the State of California. The State Supported Services contract covers abortion services for the Plan.

The onsite audit was conducted from May 21, 2019 through May 31, 2019. The audit covered the review period from May 1, 2018 through April 30, 2019 and consisted of review of documents supplied by the Plan and interviews.

An Exit Conference was held on August 15, 2019 with the Plan. There were no deficiencies found for the review period.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net Community Solutions, Inc.
AUDIT PERIOD: May 1, 2018 through April 30, 2019 DATE OF AUDIT: May 21, 2019 through May 31, 2019

STATE SUPPORTED SERVICES CONTRACT REQUIREMENTS
Abortion Contractor agrees to provide, or arrange to provide, to eligible Members the following State Supported Services: Current Procedural Terminology (CPT) Coding System Codes*: 59840 through 59857 Health Care Financing Administration (HCFA) Common Procedure Coding System Codes*: X1516, X1518, X7724, X7726, Z0336 *These codes are subject to change upon the Department of Health Care Services' (DHCS') implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic transaction and code sets provisions. Such changes shall not require an amendment to this Contract. State Supported Services Contract Exhibit A.1

SUMMARY OF FINDINGS:

The Contract requires the Plan to provide, or arrange to provide, to eligible members the following State Supported Services: CPT Coding System Codes 59840 through 59857.

Policy and Procedure Number CA.LTSS.18: Pregnancy Termination ensure members timely access to abortion services from any qualified provider without prior authorization. Members may access abortion services from any qualified contracted or non-contracted provider. The Plan monitors Participating Provider Groups (PPGs) for compliance to ensure authorization is not required for abortion services.

Members Handbook/Evidence of Coverage informs members, including adolescents (children under the age of 18), of their rights to pregnancy termination services, without a parent's consent and to receive services outside of the Plan's network without a referral.

❖ COMPLIANCE AUDIT FINDINGS (CAF) ❖
PLAN: Health Net Community Solutions, Inc.
AUDIT PERIOD: May 1, 2018 through April 30, 2019 DATE OF AUDIT: May 21, 2019 through May 31, 2019

Provider Operations Manual informs providers that prior authorization is not required for pregnancy termination (abortion) services and may be obtained from any qualified in-network or out-of-network provider. Furthermore, providers are informed that members under age 18 may access and obtain minor consent services without parental consent for abortion services.

The Plan maintains a list of CPT Codes for procedures and services which are exempt from prior authorization for the Plan's Claims Department to use in auto payment of claims submitted. The Plan's claims system configuration ensures no prior authorization is needed. The billing codes for sensitive services which are exempt from prior authorization include the CPT Codes 59840 through 59857.

There were no deficiencies identified in this review.

RECOMMENDATION:

None